STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155824	A. BUILDING **01** B. WING _____	R **12/29/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLBROOKE OF SOUTH BEND	**52565 STATE ROAD 933** **SOUTH BEND, IN 46637**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{K 000}	INITIAL COMMENTS	{K 000}		

A Post Survey Revisit (PSR) to the Life Safety Code Recertification and State Licensure Survey conducted on 11/17/15 was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).

Survey Date: 12/29/15

Facility Number: 013302
Provider Number: 155824
AIM Number: 201281730

At this PSR survey, the portion of Wellbrooke of South Bend which will be certified, the first floor, was found in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety From Fire and the 2000 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 18, New Health Care Occupancies and with 410 IAC 16.2-3.1-19, Environment and Physical standards of the Indiana Health Facilities Rules for Comprehensive care facilities.

This two story facility was determined to be of Type V (111) construction and fully sprinklered. A 2 hour fire wall is provided to divide the facility into two separate buildings. Each separate building is subdivided into two smoke compartments. Separation between the first floor healthcare occupancy and the second floor residential occupancy is provided by a 2 hour horizontal floor/ceiling assembly and fire barriers. The rated floor/ceiling system is supported by 2 hour rated construction. The facility has a fire alarm system with smoke detection in the corridor and in all areas open to the corridor. The facility

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155824	A. BUILDING **01** B. WING _____	R **12/29/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{K 000}	Continued From page 1 has smoke detectors hard wired to the fire alarm system installed in all resident sleeping rooms. The facility has a capacity of 70 and had a census of 42 at the time of this visit. All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered. Quality Review completed 01/05/16 - DA	{K 000}		